Pharmaceutical Society of Australia

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National Commission of Audit

Submission by the Pharmaceutical Society of Australia

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Version control log

Version	Date	Changes/Notes	Proposed Review Date
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Contents

Purpose

The purpose of this document is to convey the views and recommendations of the Pharmaceutical Society of Australia that address certain Terms of Reference of the National Commission of Audit.

About PSA

The Pharmaceutical Society of Australia (PSA) is the peak national professional pharmacy organisation representing Australia's pharmacists working in all sectors and locations. There are approximately 26,400 practising pharmacists[1], of whom approximately 70% work in the community sector.

PSA's core functions include: providing high quality continuing professional development, education and practice support to pharmacists; developing and advocating standards and guidelines to inform and enhance pharmacists' practice; and representing pharmacists' role as frontline health professionals.

Background

In 2012, general practitioners (GPs) and pharmacies were reported[2] to be the most highly used health care services by consumers in Australia. Between July 2011 and July 2012, 94% of Australians aged 18 years and over reported using a pharmacy health care service. This proportion increases to 99% for Australians aged 65 years and over.

In the same study, consumers provided the highest satisfaction rating for services provided by pharmacists with 89% providing a 'good-excellent' rating.

This submission recognises and supports the central role that GPs have in managing care of consumers, particularly people with chronic diseases. However, consumers increasingly report difficulty in securing a GP appointment in a timely manner to meet their health care needs and seek health care from alternative health professionals. Pharmacists are highly-skilled, accessible health professionals who can assist Government achieve fiscally sustainable, efficient and quality healthcare yet pharmacists are surprisingly underutilised in the Australian health system.

[1] Pharmacy Board of Australia. Pharmacy Registrant Data: June 2013. Available from *www.pharmacyboard.gov.au/About/Statistics.aspx*

[2] The Menzies-Nous Australian Health Survey 2012. 23 Oct 2012. Available at: *www.menzieshealthpolicy.edu.au/mn_survey/Menzies-NousAustralianHealthSurveyReport2012.pdf*

Commission Term of Reference 2:
Efficiency and effectiveness of government expenditure

Options to manage expenditure growth, including through reviewing existing policy settings, programs and discretionary spending (such as grants)

Australia faces two inter-related issues that are not adequately addressed under current policy settings and which have the potential to increase cost pressures on the Federal Budget over the near and medium term. These issues are the increasing incidence of chronic disease and the accompanying issue of medication safety.

Chronic disease: key facts[3]

- More than 7 million Australians have a chronic disease
- 8 out of 10 people aged over 65 have at least one chronic disease, and more than half of those people have two or more
- Chronic diseases occur more often among Indigenous Australians and at a much younger age
- More than half of all potentially preventable hospitalisations are from chronic conditions
- Chronic diseases:
  - account for 70% of all health expenditure
  - cause 50% of all deaths in Australia

Medication safety: key facts

Most Australians will at some stage of their lives need to take prescription and other medicines, and by the time they are 65, many people will be taking 5 or more medicines. For those with a chronic disease or mental illness, the number can be even higher.

Every year more than 217 million prescriptions are dispensed and millions more medicines are prescribed by pharmacists for minor ailments and conditions. Pharmacists play a key role in ensuring that all Australians have ready access to supplies of their essential medicines, especially those 7 million people with chronic disease.

All medicines have the potential for side effects and can interact with other medicines.

Each year 190,000 people are admitted to hospital and many more people experience reduced quality of life as a result of side effects of their medicines.

Australia spends over $16 billion each year on medicines. By comparison, we don't spend very much on medication safety and we don't pay anywhere near enough attention to reducing the occurrence and

[3] *Source:* Australian Institute of Health and Welfare *Australia's Health 2012* AIHW analysis of the 2007–08 National Health Survey.

severity of medication errors. This comes at an annual cost to the health sector of some $660 million.[4] Much of this personal and financial burden is preventable.

Research shows that deficiencies in communication are the most common contributing factor to the occurrence of medication errors, including shortcomings in communication between GPs and pharmacists.[5] It is possible that over time, e-health initiatives such as the Personally Controlled Electronic Health Record (PCEHR) will go some way to overcoming some of these shortcomings but more needs to be done. In order to be effective, strategies must go beyond a limited medical focus, and embrace stakeholders from all sectors.[6]

Pharmacists are part of the cost-saving solution

The vital service that pharmacists play in dispensing and supplying essential medicines for the community, particularly consumers with chronic diseases, is a well-established part of the fabric of our society. Indeed, this has been the key role of pharmacists under the Pharmaceutical Benefits Scheme since its inception in 1948.

Optimising the management of long-term conditions through quality use of medicines has been shown to reduce or delay the incidence of hospitalisation in patients with chronic diseases[7] and to reduce the need for and spending on expensive hospital admissions and medical services.[8]

Community pharmacies are uniquely placed within Australian communities, and are increasingly being recognised as a hub for preventive health activities. We have not made use of the full potential of pharmacists in this area, nor have we leveraged the existing network and infrastructure provided by Australia's 5,200 community pharmacies to expand the scope of services that are available for consumers with chronic disease.

It is well-recognised that many adverse health events, particularly those relating to medicines, occur when consumers are transitioning from one site of health care provision, say a hospital, to a person's home, or perhaps to a Residential Aged Care Facility. At particular risk are consumers with chronic disease, including many older people, consumers with mental illness, Aboriginal and Torres Strait Islander people and the homeless.

Pharmacists are medicines experts. The application of this expertise, alone or together with other health professionals, can improve quality of life for people taking multiple medicines, following medication review.[9]

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[4] Roughead E and Semple S. Medication safety in acute care in Australia: where are we now? Australia and New Zealand Health Policy 2009, 6: 18.

[5] Australian Commission on Safety and Quality in Health Care. Patient safety in primary health care: Discussion paper. August 2010: 7.

[6] Russell L et al. Patient Safety – handover of care between primary and acute care. Policy review and analysis. Prepared for the National Lead Clinicians Group. March 2013

[7] Kalisch LM et al. Prevalence of preventable medication-related hospitalizations in Australia: an opportunity to reduce harm. Int J Qual Health Care. 2012; 24(3): 239-49

[8] Congressional Budget Office. Offsetting Effects of Prescription Drug Use on Medicare's Spending for Medical Services. November 2012. *http://www.cbo.gov/publication/43741*.

[9] Krska J, Cromarty JA, Arris F, Jamieson D, Hansford D, Duffus PR, Downie G, Seymour DG. Pharmacist-led medication review in patients over 65: a randomized, controlled trial in primary care. Age Ageing; 2001 May;30(3):205-11

Pharmacists can help during the critical transition periods too and their involvement has been shown to decrease post-discharge readmissions[10]. As the medicines that people with chronic disease take can change when they spend some time in hospital, it is important that a pharmacist, working with the consumer's GP, undertakes a comprehensive clinical review of the medicines the person has been taking regularly and assesses if there have been any changes that have occurred during hospitalisation. These collaborative medication reviews are available to some consumers now but nowhere near all the people who need a review can receive one due to funding restrictions on the Home Medicines Review program under the Fifth Community Pharmacy Agreement.

All consumers should be able to access a medication management service when they need it and where they need it. These services can reduce avoidable admission (and readmission) to hospital and increase adherence to necessary medicines, thereby reducing overall costs of health care to government.

The following sections provide an elucidation of how the knowledge and skills of pharmacists can contribute to improved outcomes for people with diabetes and Aboriginal and Torres Strait Islander people.

Chronic disease in focus: Diabetes Mellitus

Diabetes is one of the key chronic diseases that will place increasing pressure on the Federal Budget as more Australians develop the condition. Type 2 diabetes mellitus (T2DM) is projected to become the leading cause of disease burden for males and the second leading cause for females by 2023, mainly due to the expected growth in the prevalence of obesity. A commensurate increase in annual health care costs will occur from $1.4 billion to $7 billion.[11]

For the 12 month period to June 2012, 199,182 Annual Diabetes Cycle of Care claims had been made on the Medicare Benefits Schedule (MBS).[12] This equates to approximately one service provided for every five people with diabetes (Type 1, Type 2 insulin and Type 2 non-insulin), which is consistent with a study showing that annual diabetes care plans were claimed for one in five veterans.[13] These data suggest an under-utilisation of services which facilitate coordinated management of this chronic condition. This has been recognised by the Australian Government initiative, the Diabetes Care Project, which is investigating funding models and IT systems to better coordinate care for people with diabetes. [14]

There is growing evidence that improved coordination and management of chronic (long-term) conditions results in improved utilisation of resources, including medicines and ancillary health services, leading to improved health outcomes. [15] Specifically, improving glycaemic control and adherence with diabetes

[10] Kilcup M, Schultz D, Carlson J, Wilson B. Postdischarge pharmacist medication reconciliation: Impact on readmission rates and financial savings. J Am Pharm Assoc. 2013; 53(1):78-84

[11] National Preventive Health Taskforce 2008. Australia: The Healthiest Country by 2020. A discussion paper

[12] Medicare Australia, Medicare Australia Statistics, MBS items 2517, 2518, 2521, 2522, 2525, 2526, 2620, 2622, 2624, 2631, 2633, 2635, accessed 22 November 2012

[13] Roughead EE, Barratt J, Gilbert AL, Peck R, Killer G, Diabetes processes of care in the Australian veteran population. Diabetes Research and Clinical Practice 2008 Feb; 79(2):299-304.

[14] Diabetes Care Project. *https://www.dcp.org.au/public/index.cfm*: accessed 20 December 2012.

[15] The TRIAD Study Group, Health systems, patient factors and quality of care for diabetes: A synthesis of findings from the TRIAD Study. Diabetes Care, 2010; 3(4): 940-947.

medicines has been found to reduce overall medical costs for people with diabetes in managed care plans. A US study found that prescription drug costs and direct medical costs attributable to type 2 diabetes were significantly lower for those with good glycaemic control than for those with fair or poor control. [16]

An important factor in the quality use of diabetes medicines and maintenance of glycaemic control is consumer education. It has been reported that around half of Australian adults with diabetes have not been offered structured diabetes education, and those who have receive it only at the time of initial diagnosis. [17] Australian experts have recommended that efforts to improve the cost-effectiveness of diabetes care include patient education and that educational interventions should be followed by regular reinforcement in order to sustain benefits.[18] These recommendations accord with the current focus by WHO on self-management as a way for people with diabetes to "develop confidence to manage their condition effectively and make better use of health care consultations."[19]

In its submission to the 2013-14 Federal Budget, PSA proposed the introduction of a collaborative care plan model for people with diabetes, focusing on improved self-monitoring and medication adherence, provision of individualised self-monitoring information, supporting medication management and assisting self-management to deliver better health outcomes to consumers and savings to Commonwealth Government expenditure on medicines and other health costs.[20]

Population in focus: Aboriginal and Torres Strait Islander people

Aboriginal and Torres Strait Islander people have higher incidences of chronic disease than their non-Indigenous counterparts. Together with lifestyle factors, long term medicine treatment is usually needed to prevent or reduce disease progression and thereby minimise or delay negative outcomes of ill health. Pharmacists can assist with medication adherence through simplification of medication regimens, education for self-management and ongoing support and monitoring. Improving medication adherence is often complex and multi-factorial and requires interventions at the system, provider and patient level. Pharmacists have a role to play at each of these levels. They can empower individuals, assess patient needs and tailor solutions, and maximise the benefits arising from the health system by promoting timely and equitable access to medicines and QUM education of Aboriginal and Torres Strait Islander consumers and health professionals.[21]

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[16] Oglesby AK, Secnik K, Barron J, Al-Zakwani I, Lage MJ. The association between diabetes related medical costs and glycemic control: A retrospective analysis. Cost Effectiveness and Resource Allocation 2006; 4(1).

[17] Speight J. Managing diabetes and preventing complications: what makes the difference? MJA. 2013, 198 (1): 21 Jan; 16-17.

[18] Colagiuri R, Girgis S, Eigenmann C, Gomez M, Griffiths R (2009), National Evidenced Based Guideline for Patient Education in Type 2 Diabetes. Diabetes Australia and the NHMRC, Canberra.

[19] Ibid: 30

[20] PSA's submission is available from: *http://www.psa.org.au/news/2013-federal-budget-submission*

[21] Davidson, P.M., et al., *Improving Medication Uptake in Aboriginal and Torres Strait Islander Peoples.* Heart, lung & circulation, 2010. **19**(5): p. 372-377

Research[22] indicates that 80% of the life expectancy gap (10-12 years) between Indigenous and non-Indigenous Australians could be attributed to chronic disease (heart disease 22%, diabetes 12% and liver disease 11%). Together with lifestyle factors, long term medicine treatment is usually needed to reduce disease progression.

Despite the high burden of chronic disease, there has been longstanding under-use of medicines amongst Aboriginal and Torres Strait Islander people, especially in remote areas. Barriers to accessing medicines for remote Aboriginal and Torres Strait Islander people include financial and geographic constraints, failed patient-clinician interactions, poor healthcare delivery systems and complex therapeutic medication regimens.[23] Other barriers include poverty, racism, dispossession, lack of control, the stigma associated with a diagnosis of chronic disease, educational disadvantage, shared crowded households, increased patient mobility, and inadequate health professional support.[24,25]

The Aboriginal Health Service Remote Access (AHSRA) Scheme, the Quality Use of Medicine Maximised for Aboriginal and Torres Strait Islander peoples (QUMAX) program and the Closing the Gap PBS Co-payment measure (CTG) have removed some of the financial barriers to accessing medicines, and have resulted in some increases in medicine utilisation by Aboriginal and Torres Strait Islander people. However, in order to improve the morbidity and mortality of Aboriginal and Torres Strait Islander people, the issues of medication adherence and medication education in chronic disease must be addressed. Medications need to be used appropriately and effectively, to slow chronic disease progression, reduce hospitalisations, improve morbidity and mortality rates, and improve patient lifestyle.

There is often much confusion around medicines and many remote Aboriginal and Torres Strait Islander patients still have low levels of medicine adherence relating to lack of appropriate or tailored information, and lack of health professional engagement and patient support.[26] It is likely that life expectancy will remain lower than the national average whilst chronic disease goes untreated due to lack of medicine adherence.

The AHSRA program has increased the workload of AHS staff. Aboriginal Health Workers (AHWs) and/or nursing staff are now responsible for ordering, managing and supplying medications. In addition, the AHS has to provide an adequate area for the secure and appropriate storage of medicines.[27]

Medicines are often supplied by nurses and AHWs who have little or no training about medicines and who are unable to provide adequate medicine advice to patients. They may also have little or no understanding of the appropriate labelling or recording needed when supplying medications. Education and qualification

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[22] Australian Institute of Health and Welfare. *The health and welfare of Australia's Aboriginal and Torres Strait Islander people: an overview 2011*. Cat. no. IHW 42. 2011 28 June 2011]; Available from: <http://www.aihw.gov.au/publication-detail/?id=10737418989>

[23] Larkin, C. and R. Murray, *Assisting Aboriginal patients with medication management.* Australian Prescriber, 2005. **28**: p. 123-5.

[24] Davidson, P.M., et al. *Op cit*

[25] Murray, M.D., et al., *Pharmacist intervention to improve medication adherence in heart failure: a randomized trial.* Annals of Internal Medicine, 2007. **146**(10): p. 714-25

[26] Emden, C., et al., *Better medication management for* Indigenous *Australian: findings from the field.* Australian journal of primary health, 2005. **11**(1): p. 80-90, 10.

[27] Loller, H. *NACCHO. Final report Section 100 Support Project. Report from surveys conducted in Commonwealth funded Aboriginal Health Services and Pharmacies supplying services under Section 100 Pharmacy Allowance,*. 2003; Available from:

http://www.naccho.org.au/activities/pharmaceuticalp1.html?print=yes#Pharmaceutical.

requirements of AHWs vary from state to state, as does the extent to which AHWs are legally able to perform these duties. In a recent report[28] the Senate Community Affairs References Committee laments the lack of a system for accurate and legible labelling of medicines, and recommends that "the Commonwealth Government urgently support the development and introduction of systems for accurate labelling of medicines in remote area AHSs".

Similarly, in an evaluation of the AHSRA program by the Department of Health and Ageing [29] all stakeholders argued that more needed to be done to improve the knowledge of the AHS workers about medicines and to ensure a high standard of knowledge. All stakeholders expressed the need for culturally appropriate information about medicines.

To address concerns of bulk medicine supply to AHSs and in an attempt to enhance Quality Use of Medicines (QUM), a S100 Support Allowance was introduced in 2000. This is a payment to pharmacists for the delivery of support services to AHSs. This S100 Support allowance is financially inadequate to fund more than one or two pharmacist visits per year to the AHSs. The majority of these visits relate to establishing ordering, supply and stock management systems, rather than QUM initiatives or staff education. One to two annual pharmacist visits are insufficient to provide effective QUM services to the AHSs and their outstations. The pharmacist visits are not long enough or frequent enough to build rapport, trust and effective communication with AHS staff or patients.

The Senate Community Affairs References Committee in its October 2011 report[30] recommended that remote area AHSs should have increased and direct access to the services of a pharmacist. The Committee proposed that this could be done by AHSs engaging a pharmacist directly or in collaboration with other stakeholders or service providers". The Committee also recommended that "the Commonwealth Government urgently support the development and introduction of systems for accurate labelling of medicines in remote area AHSs, and that these systems are developed to ensure accurate collection of medicine data and use. Neither of these recommendations was adopted by the previous Government.

In its submission to the 2012-13 Federal Budget, PSA proposed a project that adopts the thrust of the above recommendations from the Senate Community Affairs Committee by employing pharmacists within remote Aboriginal Health Services. These pharmacists would improve Aboriginal and Torres Strait Islander patient understanding of the role of medicines in the management of chronic disease. The pharmacists would assist patients to prevent and manage their chronic disease and provide Quality Use of Medicines education for the community and for other health professionals. As well as patient counselling, the pharmacists would ensure the accurate dispensing, labelling and recording of medicines, and collect data on clinical interventions and medication management.[31]

Rationalising the service delivery footprint to ensure better, more

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[28] Senate Community Affairs References Committee. *The effectiveness of special arrangements for the supply of Pharmaceutical Benefits Scheme (PBS) medicines to remote area Aboriginal Health Services.* October 2011. Found at: http://www.aph.gov.au/Senate/committee/clac_ctte/index.htm

[29] Australian Healthcare Associates. *Final Report: Review of the Existing Supply and Remuneration Arrangements for Drugs Listed Under Section 100 of National Health Act 1953*. February 2010.p34. Found at: http://www.health.gov.au/internet/main/publishing.nsf/Content/pharmacy-4cpa-reviews

[30] Senate Community Affairs References Committee *op cit*

[31] PSA's submission is available from ***http://www.psa.org.au/submissions/psa-submission-for-2012-13-federal-budget***

productive and efficient services for stakeholders

Making better use of pharmacists

Grattan Institute report

A recent report[32] issued by the Grattan Institute canvassed ways in which health services for consumers in rural and remote Australia could be enhanced by the more effective use of pharmacists. The report envisages these roles as collaborative exercises with GPs, building upon pharmacists' core skills and knowledge of medicines and incorporating additional training where necessary. Roles recommended for pharmacists included:

- GPs authorising pharmacists to provide repeat prescriptions
- Pharmacists working with GPs to help manage chronic care
- Pharmacists administering vaccinations

Importantly, the Grattan Institute notes that "compared to other countries, pharmacists have a very limited role in delivering primary care in Australia"[33]. In part, this is due to a siloed approach to primary care under which the Commonwealth's funding arrangements determine the services provided by differing health care professionals. These arrangements appear to be based on an outdated policy perspective that takes insufficient account of present-day skills-mix and availability of different health professionals.

Australia's 61 Medicare Locals have recently undertaken health needs assessments of their local communities. As such, these Medicare Locals are well-placed to co-ordinate the range of services that can meet the needs of their communities in the most efficient and effective manner. The Grattan Institute's recommendations on the roles that pharmacists can play in filling the service gaps faced by particular communities represent a good starting point for the provision of more effective health services through Medicare Locals (or other meso-level primary health care organisations).

Existing Commonwealth programs

The large burden of medication misadventure was noted earlier. Despite this growing cost to the Federal Budget, existing programs that could be used to help address the problem are not being used to their full potential. For example, under the Practice Nurse Incentive Program (PNIP)[34], a GP can engage the skills of a practice nurse and/or a range of 14 different types of allied health practitioners but not a pharmacist.

Similarly, the Practice Incentives Program–Quality Prescribing Incentive cannot be used by a GP to employ the services of a non-dispensing pharmacist despite the clear focus of the program being around the quality

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[32] Duckett S. and P. Breadon. Access all areas: new solutions for GP shortages in rural Australia. Grattan Institute Report No. 2013-11, September 2013.

[33] Ibid: p.22

[34] Information on the PNIP is available from *http://www.medicareaustralia.gov.au/provider/incentives/pnip.jsp*

use of medicines. The inclusion of a pharmacist as an option for a GP to consider to address the needs of patients under these two programs could go some way to reducing the personal and financial burden of medication misadventure and would represent the provision of more effective health services.

By way of contrast, the criteria for the Medical Specialist Outreach Program–Indigenous Chronic Disease was broadened in recent years to enable the inclusion of a pharmacist in the health care team servicing Aboriginal and Torres Strait Islander people in rural and remote communities. Several applications have been successful and pharmacists are now providing much-needed outreach medication management services to Indigenous patients with chronic disease in areas as diverse as Cape York and Wilcannia. It is important to recognise that the inclusion of pharmacists in this program has led directly to the provision of better, more productive and efficient services for patients with chronic disease in these communities.

There is considerable scope for a similar approach to be undertaken across a range of programs administered by the Department of Health such as the Practice Nurse Incentive Program and the Practice Incentives Program–Quality Prescribing Incentive, as canvassed above.

Prescribing by pharmacists

Commonwealth, State and Territory Health Ministers meeting as the Standing Committee on Health have recently approved the Health Professionals Prescribing Pathway (HPPP)[35] which will provide a way for health professionals, including pharmacists, to prescribe medications. The HPPP has been developed by Health Workforce Australia in consultation with a broad range of stakeholders. The HPPP sets out the steps required for a health professional to achieve safe and competent prescribing of medicines within their scope of practice.

Patient-centred medical home

The patient-centred medical home has been proposed as a model for transforming primary health care and improving the efficiency and effectiveness of the health system, particularly for consumers with chronic disease. The principal feature of this model is the identification of a health care professional who leads a team which takes responsibility for all the health-care needs of an individual and coordinates care with other health professionals. Payment systems reward the added value provided by the medical home.

The patient-centred medical home is receiving increasing attention in Australia by both the Federal government and health organisations including the AMA and RACGP. While much of the literature around the medical home has been focussed on transforming General Practices into a medical home, PSA proposes the development of a value proposition that draws upon pharmacists' unique contribution to patient care through the provision of medication management services. This contribution of pharmacists has arguably been under-recognised to date, as highlighted in the recent Grattan Institute Report[36] and discussed above.

While medication management programs funded through successive Community Pharmacy Agreements programs (such as Home Medicine Reviews) have been a good starting point for raising awareness of the

[35] The final HPPP is available from *http://www.hwa.gov.au/sites/uploads/The-Health-Professionals-Prescribing-Pathway-Nov13.pdf*

[36] Duckett, S. *op cit*

contribution of pharmacists in a collaborative care environment, their limitations (capped budgets; siloed funding; lack of integration) have impacted on the capacity of these programs to improve patient outcomes. The patient-centred medical home model offers an opportunity to embed medication management services in a more effective manner within primary care settings.

In the following conceptualisation of the patient-centred medical home, the pharmacist's contribution is depicted in all the settings that consumers move through, and captures those services delivered from a community pharmacy, as well as those that can be provided by pharmacists in other locations. Further investigation of the roles that pharmacists can play in the patient-centred medical home provides the opportunity to achieve greater efficiencies in the way health services are delivered and enhance the effectiveness of the services that are provided to consumers in the primary care setting.

Pharmaceutical Society of Australia

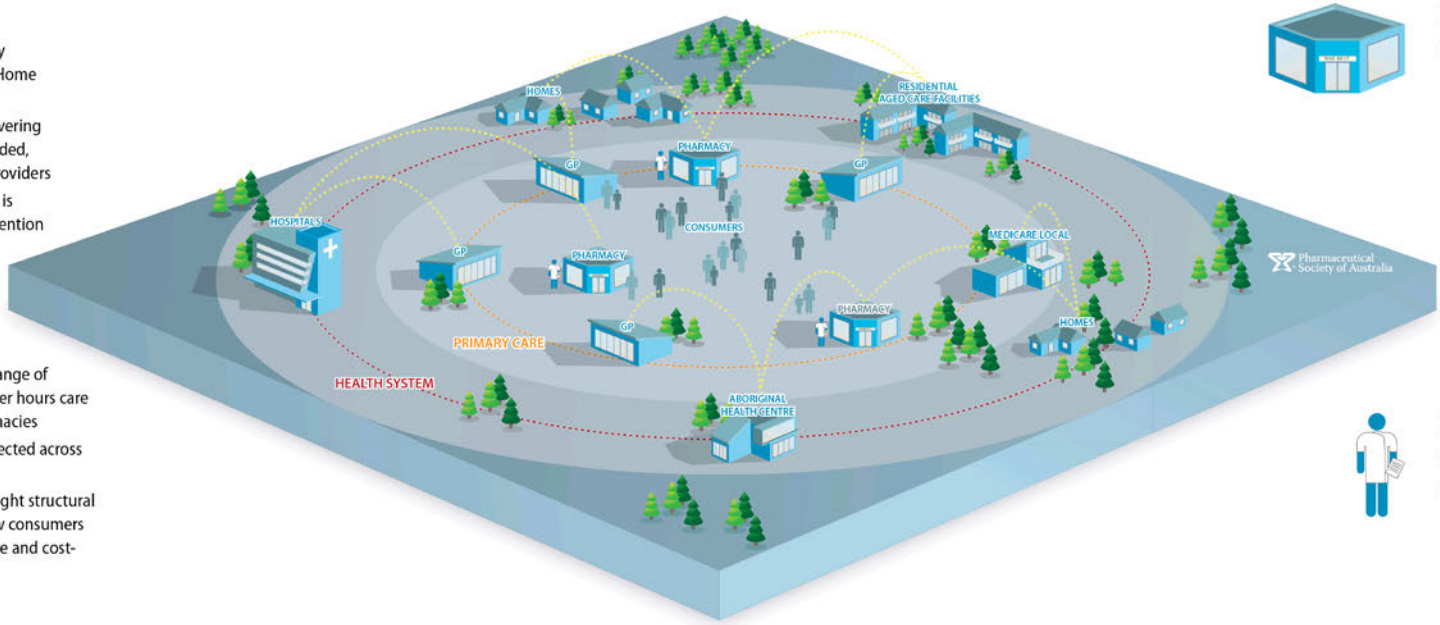
Pharmacists and the patient-centred medical home

Key features

PSA's proposals seek to align with the key features of the Patient-Centred Medical Home model, in that they are:

- Patient-centred – pharmacists are delivering services where and when they are needed, and in collaboration with other care providers
- Comprehensive – the focus of services is across the spectrum of care, from prevention to chronic disease care
- Coordinated – the contribution of the pharmacist is part of the broader health care system, with effective documentation and communication
- Accessible – having pharmacists in a range of settings increases accessibility, and after hours care is available at many community pharmacies
- Committed to quality and safety – reflected across all of the proposed programs

Underpinning this approach is that the right structural and funding systems are in place to allow consumers to move to the most clinically appropriate and cost-effective setting.



Pharmacy = Health care destination

» Safe and quality dispensing of PBS/RPBS Optimising medicines management
» Public health programs:
  - health promotion
  - screening and risk assessment
  - brief interventions
  - chronic disease monitoring
» Triage and minor ailments service

Pharmacist = Health care clinician

Collaborative medication management in:
» consumers' homes
» residential aged care facilities
» Aboriginal health services
» General Practices
» community and hospital pharmacies

Health system enablers

Health work force
IT/eHealth
Funding arrangements

Primary care enablers

After-hours
eHealth
Australian Primary Care Collaboratives

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Concluding Comments

PSA welcomes the National Commission of Audit and its focus on ensuring the delivery of effective and efficient services to the Australian community. PSA would be pleased to work with the Commission and the Government to develop and implement a broader range of services delivered by pharmacists, as outlined in this submission.

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